REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

MEDICARE PART D - UPDATE

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SEAL

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Preface

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) created Medicare Part D and was enacted on December 8, 2003. Medicare Part D offers outpatient prescription drug coverage for Medicare beneficiaries who enroll. Beneficiaries in Medicare fee-for service may seek coverage through a stand-alone prescription drug plan (PDP) or through a Medicare Advantage Prescription Drug (MA-PD) plan which covers all Medicare benefits. The Kaiser Family Foundation reported in February 2007, 43 million or 81% of Medicare beneficiaries were enrolled in a fee-for-service program and 8.3 million or 19% were enrolled in a Medicare Advantage plan. Medicare Advantage plans are "private health plans that receive payments from Medicare" and may receive a small additional monthly fee from the Medicare beneficiary. (Source: Kaiser Family Foundation, *Medicare Fact Sheet on Medicare Advantage*, February 2007.)

In June 2006, staff of the Joint Commission on Health Care (JCHC) provided an update on such Medicare Part D issues as cost sharing under the prescription drug benefit, and provisions related to dual eligibles and low-income beneficiaries. In addition, JCHC staff reported that 18 companies offered 41 Medicare prescription drug plans (PDPs) and 10 companies offered 26 Medicare Advantage Prescription Drug (MA-PD) plans in Virginia. In exchange for the federal government generally assuming the cost of prescription drug coverage for dual eligibles, Virginia was expected to have a "clawback" payment to the federal government of $165,787,204 in FY 2007 and $178,243,970 in FY 2008. (Dual eligibles are individuals who are eligible for both Medicare and Medicaid benefits.)

Kim Snead
Executive Director

March 2007

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Executive Summary

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) created Medicare Part D and was enacted on December 8, 2003. Medicare Part D offers outpatient prescription drug coverage for Medicare beneficiaries who enroll. This prescription coverage first became available on January 1, 2006. Medicare beneficiaries with fee-for service plans may obtain coverage through a stand-alone prescription drug plan (PDP) or through a Medicare Advantage Prescription Drug plan (MA-PD) which covers all Medicare benefits. The Kaiser Family Foundation reported in February 2007, 43 million or 81% of Medicare beneficiaries were enrolled in a fee-for-service program and 8.3 million or 19% were enrolled in a Medicare Advantage plan. Medicare Advantage plans are "private health plans that receive payments from Medicare" and may receive a small additional monthly fee from the Medicare beneficiary. (Source: Kaiser Family Foundation, *Medicare Fact Sheet on Medicare Advantage*, February 2007.)

Cost-Sharing

Under the prescription drug benefit offered by Medicare Part D in 2006, beneficiaries:

- Pay the first $250 in drug costs (deductible);
- Between $250 and $2,250, pay 25% of total drug costs;
- Between $2,250 and $5,100, pay 100% of total drug costs possibly up to $2,850 out-of-pocket. This is commonly referred to as the "donut hole.";
- Pay the greater of $2 for generics, $5 for brand drugs, or 5% co-insurance, once the catastrophic threshold for drug costs of $5,100 is reached.

Premiums average $32.20 per month, but vary greatly by plan and region.

Dual Eligibles

In light of prescription drug coverage by Medicare Part D, state Medicaid programs are no longer responsible for providing drug coverage for dual eligibles. (Dual eligibles are individuals who are eligible for both Medicare and Medicaid benefits.) All dual eligibles are required to enroll in a Part D plan; however, they are not responsible for paying monthly premiums, deductibles, or co-pays for drug costs over $5,100. Dual eligibles with incomes below 100% of FPL must pay $1 to $3 co-pays and dual eligibles with incomes over 100% of FPL must pay $2 to $5 co-pays.

In exchange for no longer providing prescription drug coverage for dual eligibles, State Medicaid programs are required by federal law to help finance Part D through what has been termed the "clawback." The "clawback" formula relies on a per capita expenditure that is largely based on a state's Medicaid spending for prescription drugs for dual eligibles in calendar year 2003. As of June 2006, Virginia's "clawback" payments were estimated to be $165,787,204 for FY 2007 and $178,243,970 for FY 2008.

Low-Income Beneficiaries

Medicare beneficiaries, with incomes below 135% of FPL and assets of less than $6,000 (or $9,000 for a couple), receive a subsidy to cover the average monthly premium for basic coverage in their region. These beneficiaries do not have deductibles, but are required to pay $2 to $5 co-pays until $5,100 in total drug costs have been paid out during the year.

Medicare beneficiaries, with incomes below 150% of FPL and assets less than $10,000 (or $20,000 for a couple), receive a sliding scale premium subsidy, but have a $50 deductible. Below $5,100 in drug costs, they must pay 15% co-pays and once the $5,100 is reached, the beneficiaries are responsible for $2 to $5 co-pays.

Part D Plans in Virginia

As of June 2006, 18 companies offered 41 Medicare prescription drug plans (PDPs) and 10 companies offered 26 Medicare Advantage Prescription Drug (MA-PD) plans in Virginia.

JCHC Staff for this Report

Catherine W. Harrison
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Medicare Part D Update

(Revised)

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Long-Term Care/Medicaid Reform Subcommittee
Joint Commission on Health Care

Catherine W. Harrison
Senior Health Policy Analyst

June 14, 2006
Richmond, Virginia

Presentation Outline

- ■ *Background on Medicare Part D*
- ❑ **Implementation of Medicare Part D**

Medicare Benefits

- The benefits under Medicare are often referred to in alphabetical terms. The following list provides a short summation of covered benefits:
  - **Part A** - typically referred to as the hospital insurance component of fee-for-service Medicare, assists in the payment of inpatient hospital services, short-term skilled nursing facility services, certain home health services and hospice care.
  - **Part B** - often referred to as the medical insurance component of fee-for-service Medicare, helps pay for physician services, outpatient hospital services, certain home health services, medical equipment and supplies, and other health services and supplies.
  - **Part C** - previously called Medicare +Choice but now renamed Medicare Advantage, allows Medicare beneficiaries to select health plans (such as health maintenance organizations and preferred provider organizations).
  - **Part D** – offers outpatient prescription drug coverage for Medicare beneficiaries as optional coverage.

Medicare Part D Prescription Drug Benefit

- The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was enacted on December 8, 2003.
  - Created Medicare Part D.
- Individuals who are entitled to Part A or enrolled in Part B of Medicare may receive prescription drug coverage under Part D.
- Participation in Part D is voluntary. *(However, a penalty amount, based on 1% of the base beneficiary premium for each month the individual does not have qualifying coverage, will be assessed if the individual does not enroll when they first qualify or when they no longer have drug coverage that is actuarially equivalent.)*
  - The initial enrollment period extended from January 1, 2006 to May 15, 2006.
- The drug benefit is administered through private health plans.
  - Beneficiaries enrolled in Medicare fee-for-service may seek coverage through a stand-alone prescription drug plan (PDP).
  - Beneficiaries may also seek prescription drug coverage through a Medicare Advantage Prescription Drug (MA-PD) plan which covers all Medicare benefits.

Medicare Part D Cost-Sharing

- Under the prescription drug benefit offered under Medicare Part D in 2006, beneficiaries will:
  - Pay the first $250 in drug costs (deductible);
  - Between $250 and $2,250, pay 25% of total drug costs;
  - Between $2,250 and $5,100, pay 100% of total drug costs possibly up to $2,850 out-of-pocket. This is commonly referred to as the "donut hole.";
  - Once the catastrophic threshold for drug costs of $5,100 is reached, the individual pays the greater of $2 for generics, $5 for brand drugs, or 5% co-insurance.
- Deductibles, benefit limits, and catastrophic thresholds are indexed to rise with the growth in per capita Part D spending.
- Premiums average $32.20 per month for basic coverage; but actual premiums vary substantially by plan and region.
- Only a small percentage of PDPs and MA-PDs provide the basic benefit outlined above. National variations include:
  - Almost all plans charge different co-pays based on the covered drug;
  - 58% of PDPs and 79% MA-PDs do not have a deductible; and
  - 2% of PDPs and 5% MA-PDPs offer coverage during the "donut hole."

TrOOP

- Medicare Part D "true out-of-pocket costs" are commonly referred to as TrOOP.
- Part D catastrophic coverage is based on an individual's TrOOP.
- The standard Part D benefit has an out-of-pocket cost or TrOOP limit of $3,600.
- For a standard Part D beneficiary, primarily costs paid by the beneficiary and not by most third-party insurers (such as supplemental insurance by a former employer) are used when calculating an individual's TrOOP costs.
  - However, certain payments from third parties are included in the TrOOP calculation; including assistance provided by:
    - Family members
    - The Medicare low-income subsidy
    - State pharmaceutical assistance programs (SPAPs) and
    - Charities unaffiliated with employers or unions.
- Part D beneficiaries receive periodic statements from their PDP on the status of their TrOOP.

Medicare Part D Cost-Sharing for Medicaid Dual Eligibles

Dual Eligibles with Income<100%FPL

- Receive their drug benefit through Medicare.
- No premium.
- No deductible.
- Below the catastrophic threshold, individual **pays $1 to $3 co-pays.**
- Not responsible for co-pays once total drug costs reach $5,100.
- Institutionalized individuals are not responsible for cost-sharing.

Dual Eligibles with Income>100%FPL

- Receive their drug benefit through Medicare.
- No premium.
- No deductible.
- Below the catastrophic threshold, individual **pays $2 to $5 co-pays.**
- Not responsible for co-pays once total drug costs reach $5,100.
- Institutionalized individuals are not responsible for cost-sharing.

Medicare Part D Cost-Sharing for Low-Income Beneficiaries

Beneficiary Income < 135% FPL and Assets < $6,000 ($9,000 for a couple)

- Receive a subsidy to cover the average monthly premium for basic coverage in their region.
- No deductible.
- Below the catastrophic threshold, individual **pays $2 to $5 co-pay**.
- Not responsible for co-pays once total drug costs reach $5,100.

Beneficiary Income < 150%FPL and Assets < $10,000 ($20,00 for a couple)

- Receive premium subsidies on a sliding scale.
- $50 deductible.
- Below the catastrophic threshold, individual pays **15% co-pay**.
- Responsible for $2 to $5 co-pays once total drug costs reach $5,100.

Additional Information for Medicare Beneficiaries

- Medicare beneficiaries can gather additional information about prescription drug coverage by:
  - Calling 1-800-MEDICARE (1-800-633-4227); TTY users should call 1-877-486-2048.
  - Accessing the Medicare website at www.medicare.gov.
  - Reading the new "Medicare and You 2006" handbook delivered through the mail in October 2005.
- For additional information on applying for Part D and low-income assistance, individuals may contact the Social Security Administration by:
  - Calling 1-800-772-1213; TTY users should call 1-800-325-0778.
  - Visiting the website www.socialsecurity.gov.

Presentation Outline

- ❑ **Background on Medicare Part D**
- ■ ***Implementation of Medicare Part D***

Medicare Part D Prescription Drug Benefit Enrollment

- The initial enrollment occurred from November 15, 2005 until May 15, 2006. The enrollment period in following years will extend from November 15 to December 31.
- A late enrollment penalty will apply if a beneficiary does not enroll in the Part D benefit at the first available opportunity.
- Beneficiaries may choose a plan from options available in their geographic area.
  - Dual eligibles who did not elect a plan were automatically enrolled in a plan by CMS.

Medicare Part D Enrollment for Low-Income Beneficiaries

- Low-income Medicare beneficiaries may apply for subsidies through the state Medicaid office or the Social Security Administration (SSA).
- Certain individuals are automatically deemed eligible for low-income subsidies, including:
  - Dual eligibles (individuals eligible for Medicare Part A and/or Part B and Medicaid benefits);
  - Medicare Savings Program (MSP) beneficiaries (QMBs, SLMBs, etc.); and
  - SSI recipients.
- SSA and CMS began mailings to and accepting applications from beneficiaries eligible for low-income subsidy during 2005. SSA began processing applications for assistance on July 1, 2005.
  - CMS automatically enrolled dual eligibles, if they had not chosen a plan by December 31, 2005.
  - CMS facilitated enrollment of SSI recipients or MSP beneficiaries who had not chosen a plan by May 15, 2006.

Medicare Part D Enrollment Activities in Virginia

- The Virginia Department for the Aging has provided information about Part D to the public through:
  - The agency's website
  - Printed materials
  - Presentations throughout the state
  - Information at public events
  - Training and information to other agencies and
  - Responding to telephone calls (11,208 calls from 1/1/06 to 5/31/06).
- Area agencies on aging, through the Virginia Insurance Counseling and Assistance Program (VICAP), provided individual counseling about Part D.
  - 16,387 beneficiaries received direct counseling services from 1/1/06 to 5/31/06.
  - More than 16,600 hours were spent offering face-to-face (office and home visits) and telephone counseling.
  - 174 public presentations and events (totaling 484 hours) were conducted reaching approximately 13,400 beneficiaries.

Medicare Part D Enrollment Activities in Virginia

- The Department of Medical Assistance Services has been involved in informing beneficiaries of the Part D benefit:
  - Sent several mailings to dual eligibles
  - Notified prescribing providers of changes associated with Part D
  - Created the Medicare Part D Task Force with more than 75 individual participants
  - Provided access to training programs/materials about Part D
  - Conducted an all-day training program featuring CMS and SSA staff via videoconference to 31 sites
  - Provided assistance in resolving specific case problems.
- Local social services offices continue to provide assistance to individuals enrolling in Part D, including low-income individuals applying for additional assistance.

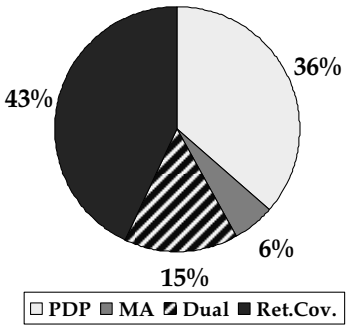
Medicare Part D Enrollment Data

- According to CMS, Virginia had 1,000,145 Medicare beneficiaries in January 2006.
- As of 5/7/06, 737,509 Medicare beneficiaries in Va. were receiving creditable prescription drug coverage through:
  - Medicare PDPs (268,277);
  - Medicare Advantage plans (40,800);
  - Dual eligible status (110,201); and
  - Medicare retiree subsidy and federal retiree programs (318,231).

(Figures do not include all forms of creditable coverage such as Veteran's Administration benefits.)

Prescription Coverage for Part D Beneficiaries in Virginia

(Source: CMS as of 5/7/06)



Medicare Part D Plans in Virginia

- PDPs – 18 companies offering 41 plans.
- Medicare Advantage Prescription Drug Plans – 10 companies offering 26 plans.
- Top 5 PDPs in Virginia as of 4-27-06:
  - United Healthcare;
  - Humana Insurance Company;
  - Blue MedicareRx;
  - MEMBERHEALTH; and
  - WellCare.
- Top 5 PDPs enrolling dual eligibles as of 4/27/06:
  - United Healthcare;
  - MEMBERHEALTH;
  - Humana Inc.;
  - WellCare; and
  - CIGNA HealthCare.

Medicaid and the Medicare Drug Benefit

- Beginning January 1, 2006, Medicaid no longer provides (with certain exceptions) prescription drug coverage for individuals eligible for full Medicaid benefits and Medicare Part D.
- States are responsible for paying part of the cost of providing prescription drug coverage for these dual eligibles.
  - Payments to the federal government have been named the "clawback."
    - "Clawback" formula relies on a per capita expenditure that is largely based on a state's Medicaid spending for prescription drugs for dual eligibles in calendar year 2003.

"Clawback" in Virginia

Estimated Clawback Payments		
	Gov's Intro. Budget	Revised Estimate
FY 06	$72,030,733	$64,480,649
FY 07	$185,692,649	$165,787,204
FY 08	$199,558,382	$178,243,970

- DMAS' clawback cost estimates have been revised as CMS has made several changes to the clawback calculation including:
  - Reducing the drug cost estimate used in the clawback calculation and
  - Using revised base period (2003) eligibility files.

Medicare Part D Activities in Other States

- In 2006, 28 states introduced legislation related to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.
  - Many of the proposed state changes included:
    - Temporary drug coverage for dual eligibles;
    - State Pharmaceutical Assistance Program (SPAP) revisions; and
    - Coverage of drugs for dual eligibles not covered under Part D.
  - To date, legislation has been passed in 12 states.
- In response to initial problems with the Part D program, 37 states and the District of Columbia elected to implement Transitional and Emergency Coverage.
  - Governor Kaine issued Executive Order 9 (1/31/06) directing DMAS to initiate payment of prescription drug claims for dual eligibles.
    - Coverage extended from 1/31/06 – 3/8/06.
    - Under a waiver from CMS, DMAS paid $5.5 million for Part D medications.
    - DMAS is pursuing full reimbursement from CMS.
  - State Medicaid directors have reported on problems associated with Part D including:
    - Beneficiaries charged incorrect cost-sharing (49 states);
    - Pharmacies unable to bill prescription drug plans (44 states); and
    - Beneficiaries could not obtain non-formulary drugs (43 states).

Pharmaceutical Companies and Medicare Part D

- Upon the creation of Part D, pharmaceutical companies examined their patient assistance programs (PAPs) to determine the impact of the new Medicare benefit.
  - Concerns regarding anti-kickback law and the PAPs interaction with TrOOP.
- Several companies have decided to continue their current PAPs and/or create new PAPs. Examples include:
  - Eli Lilly (LillyAnswers and LillyMedicareAnswers).
  - Johnson and Johnson and additional manufacturers (Companion Rx Program which would target the “donut hole”).
  - Schering-Plough.

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